

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2993

CERTIFICATE OF DEATH

02885

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>W. Va.</u>		COUNTY <u>Barbour</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Oakland</u>		LENGTH OF STAY (in this place) <u>6 Mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Philippi,</u>		<u>85x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Philippi, W. Va.</u>			
3. NAME OF DECEASED (Type or Print) <u>Ella</u> (First) <u>Douglas</u> (Middle) <u>Benson</u> (Last)				4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>ch 21</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 20, 1871</u>	9. AGE last birthday <u>84</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Douglas</u>				14. MOTHER'S MAIDEN NAME <u>Prudence Holden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>403 Washington St. Cloris Benson Cumberland, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Hypostatic pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Heart Disease</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Atherosclerosis</u>				<u>10 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 16</u> , 19 <u>56</u> , to <u>March 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 21</u> , 19 <u>56</u> , and that death occurred at <u>9:25A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. S. Mance</u>		M. D. <u>Oakland Md</u>		DATE SIGNED <u>21 March 1956</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/24/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon Memorial Cem., Philippi, W. Va.</u>		LOCATION (City, town, or county) (State) <u>Oakland, Md.</u>	
24. REC'D BY REGISTRAR <u>3/23/1956</u>		REGISTRAR'S SIGNATURE <u>Julia H. Rowan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Berkert C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE		9. OCCUPATION		10. CAUSE OF DEATH		11. PLACE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	

BUREAU V. S.

MAR 29 1956

RECEIVED

NOTICE: This certificate is to be filled out by the physician or other qualified person who has attended the deceased. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. The certificate is to be filled out in duplicate. One copy is to be retained by the physician or other qualified person, and the other copy is to be forwarded to the Registrar of the State Department of Health, Baltimore, Maryland. The certificate is to be filled out in duplicate. One copy is to be retained by the physician or other qualified person, and the other copy is to be forwarded to the Registrar of the State Department of Health, Baltimore, Maryland.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital of the attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

040529

2904

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Star Route</u>				d. STREET ADDRESS <u>Star Route</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Wilson</u> Last <u>Bills</u>				4. DATE OF DEATH Month <u>3</u> Day <u>30th</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 / 3 / 1890</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>Wheeling, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Henry G. Bills</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <u>Yes</u>		16. SOCIAL SECURITY NO. <u>World I</u>		17. INFORMANT <u>Star Route</u>			
		<u>052-01-8966</u>		<u>Mrs. Leona Bills Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January, 1956</u> to <u>present</u> , 19 <u>56</u> that I last saw the deceased alive on <u>March 24, 1956</u> , and that death occurred at <u>4:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ruth Peachey</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Grantsville, Md. Mar 30/56</u>			
PHYSICIAN'S NAME (Type) <u>Ruth Peachey M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4 / 1 / 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. H. Mattingly</u>				23. E. Main ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-3-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. H. Roe</u>			

Hafer Funeral Home

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2905

CERTIFICATE OF DEATH

02886 6

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 GARRETT COUNTY MEMORIAL				d. STREET ADDRESS CRELLIN			
3. NAME OF DECEASED (Type or print) First GUS Middle DE LAUDER Last DE LAUDER				4. DATE OF DEATH Month MARCH Day 21 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 1, 1873		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN DE LAUDER				14. MOTHER'S MAIDEN NAME ELIZABETH HALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK.		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Theresa Wellington		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2. BR. ILLATION (c) SEMI-17.						INTERVAL BETWEEN ONSET AND DEATH 1 HOUR YRS YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1950 , 19____, to 3-21 , 19 56 , that I last saw the deceased alive on 3-21 , 19 56 , and that death occurred at 5 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Feaster, Jr.				ADDRESS (Street, city or town, state) 582nd St. Oakland, Md			
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.				DATE SIGNED 3.21.56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Oakland		22d. LOCATION (City, town, or county) (State) Oakland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Bolden				ADDRESS Oakland Md		24a. REC'D BY REGISTRAR DATE 3/24/56	
				24b. REGISTRAR'S SIGNATURE Julius Rowan, LR			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 29 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2906
CERTIFICATE OF DEATH

02887
166

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA LENA EGGERS.				4. DATE OF DEATH Month Day Year MARCH 17 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH-30-1873	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OAKLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME HENRY EGGERS.				14. MOTHER'S MAIDEN NAME MARGARET SHAFER.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address W.E. EGGERS. OAKLAND MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 years 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 15, 1949 , to March 17, 1956 , that I last saw the deceased alive on March 17, 1956 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A.E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 18 March 1956			
PHYSICIAN'S NAME (Type) A. E. Mance, M.D.				Oakland, Maryland March 18, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH-20-1956		22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD.		24a. REC'D BY REGISTRAR DATE 3/20/56 24b. REGISTRAR'S SIGNATURE Julius R. Rouse	

MAR 29 1956

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02888

2907 CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Garrett		STATE West Virginia COUNTY Preston		CITY Terra Alta		CITY Terra Alta	
CITY Oakland		LENGTH OF STAY 12 days		CITY Terra Alta		CITY Terra Alta	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Evans Nursing Home		STREET ADDRESS Washington Avenue		CITY Terra Alta		CITY Terra Alta	
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) Samuel		(Middle) Elsworth		(Last) Elsley		(Month) March 9, 1956	
(Type or Print)						(Day) 19	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
Male	White	Married	June 11, 1879	76 yrs.	8 Months 28 Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Telegraph Operator B&O R R Co			Terra Alta, West Virginia		U S A		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Benjamin H. Elsley				Almeda DeBerry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		705-12-2699		Mrs. Bessie Jeraldine Elsley, Terra Alta W Va			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A)				Interval between ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				1 week			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				3 yrs			
(B) Cardio-renal vascular disease				3 yrs			
(C) Arteriosclerosis				3 yrs			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Cerebral Hemorrhage 3 wks ago 1st (Bronchopneumonia)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		Old emphysema					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 2</u>, 19<u>56</u>, to <u>Mar 9</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Mar 9</u>, 19<u>56</u>, and that death occurred at <u>8 P</u>.M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Charles E. Smith				3/10/56			
M.D. Terra Alta, West Virginia							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		March 12, 1956		Terra Alta Cemetery		Terra Alta, W.Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 3/12/56		Julius A. Rowan L.R.		P. R. Watson, Terra Alta, W.Va.			

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 15878 166 CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Signature of physician

10. Signature of registrar

11. Date of registration

12. Signature of informant

13. Name of informant

14. Address of informant

15. Signature of informant

16. Signature of physician

17. Name of deceased

18. Sex

19. Race

20. Date of birth

21. Place of birth

22. Date of death

23. Place of death

24. Cause of death

25. Signature of physician

26. Signature of registrar

27. Date of registration

28. Signature of informant

29. Name of informant

30. Address of informant

31. Signature of informant

32. Signature of physician

33. Name of deceased

34. Sex

35. Race

36. Date of birth

37. Place of birth

38. Date of death

39. Place of death

40. Cause of death

41. Signature of physician

42. Signature of registrar

43. Date of registration

44. Signature of informant

45. Name of informant

46. Address of informant

47. Signature of informant

48. Signature of physician

BUREAU V. S.

MAR 19 1956

RECEIVED

3/19/56
J. J. [Signature]
[Signature]

2908

CERTIFICATE OF DEATH

02889

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY TUCKER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAVIS 85x-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VERONA Middle B. Last EUBANK		4. DATE OF DEATH Month MARCH Day 2 Year 19 56					
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25, 1874		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAMS, E.F.				14. MOTHER'S MAIDEN NAME GRIMES, MARGARET			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. H. A. MEYER		Address DAVIS, W.VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephrosis (c) Coronary Heart Failure						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 1, 1956 , to March 2, 1956 , that I last saw the deceased alive on March 2, 1956 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. F. Baumgartner M.D.				ADDRESS (Street, city or town, State) 2500 Cedar St - Oakland Md DATE SIGNED 3/2/56			
PHYSICIAN'S NAME (Type) E. I. BAUMGARTNER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/56		22c. NAME OF CEMETERY OR CREMATORY Warm Springs Va.		22d. LOCATION (City, town, or county) (State) Warm Springs Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle				ADDRESS Davis, Wva.		24a. REC'D BY REGISTRAR DATE 3/7/56	
				24b. REGISTRAR'S SIGNATURE Julia A. Hower			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 7 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

* 2909 CERTIFICATE OF DEATH

02890

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u> COUNTY <u>GARRETT</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>OAKLAND</u>		LENGTH OF STAY (in this place) <u>8 days</u>		TOWN <u>FRIENDSVILLE</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>HARVEY</u>		(Middle) <u>WILLIAM</u>		(Last) <u>FIKE</u>		DATE <u>MARCH 25 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>MARCH 22, 1881</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARSHALL FIKE</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3 17</u> , 19 <u>52</u> , to <u>3 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 26</u> , 19 <u>56</u> , and that death occurred at <u>12 15 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James H. Fenton</u>		M.D. <u>5824 St. Oakland</u>		DATE SIGNED <u>3 25 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/28/56</u>		NAME OF CEMETERY OR CREMATORY <u>Friendsville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Friendsville, Md</u>	
24. REC'D BY REGISTRAR <u>2/26/56</u>		REGISTRAR'S SIGNATURE <u>Julia Howard</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jack R. Friend</u>		ADDRESS <u>Friendsville</u>	

DEATH CERTIFICATE

Form No. 10-1-55

1. GROUPE NÉCESSAIRE (NOM ET PRÉNOM)

2. GROUPE NÉCESSAIRE (NOM ET PRÉNOM)

3. GROUPE NÉCESSAIRE (NOM ET PRÉNOM)

4. GROUPE NÉCESSAIRE (NOM ET PRÉNOM)

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99. GROUPE NÉCESSAIRE (NOM ET PRÉNOM)

100. GROUPE NÉCESSAIRE (NOM ET PRÉNOM)

RECEIVED

NOTICE: This certificate is to be filled out by the attending physician or the medical examiner. It is to be signed and dated by the physician or examiner. It is to be filed in the office of the health officer. It is to be kept for a period of one year. It is to be made available to the public upon request. It is to be made available to the public upon request.

BUREAU V. S.

MAR 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2916 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) NEAR SANG RUN, MD.</u>		c. LENGTH OF STAY IN 1b <u>LIFETIME</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRIENDSVILLE, MARY LAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First <u>FORD</u> Middle <u>QUINTEN</u> Last <u>FRIEND</u> </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month <u>MARCH</u> Day <u>22ND.</u> Year <u>1956</u> </div>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 26TH., 1918</u>		9. AGE (In years last birthday) <u>37</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>CORNELIUS WARD FRIEND</u>				14. MOTHER'S MAIDEN NAME <u>LIZZY MAE FRIEND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> <u>WORLD WAR II</u>		16. SOCIAL SECURITY NO. <u>20816-4654</u>		17. INFORMANT <u>OLIN FRIEND</u> Address <u>FRIENDSVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FRACTURED SKULL</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BROKEN NECK</u> DUE TO (c) <u>CRUSHED CHEST</u> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>CRUSHED VICTIM WHILE WORKING UPON ROCK IN A STONE QUARRY.</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:15</u> o. m. <u>3-22</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>COUNTY STONE QUARRY SANG RUN GARRETT MD.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, JR., M. D. ACTING</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blooming Rose</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack D. Friend</u>		ADDRESS <u>Friendsville</u>		24a. REC'D BY REGISTRAR <u>March 23/56</u>			
24b. REGISTRAR'S SIGNATURE <u>Mr. Ruth F. ...</u>		DATE SIGNED <u>MARCH 22, 1956</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text and includes checkboxes for various conditions.

RECEIVED
MAR 27 1956
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2911

CERTIFICATE OF DEATH

02892
02892/6

Item 9, Film 194 3-23-56 et

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS BOX # 29			
3. NAME OF DECEASED (Type or print) First GEORGE Middle HOWARD Last GLOTFELTY				4. DATE OF DEATH Month MARCH Day 4 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 12, 1877	9. AGE (In years last birthday) 78 7/10 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - RETIRED				10b. KIND OF BUSINESS OR INDUSTRY OWN FAAM		11. BIRTHPLACE (State or foreign country) MARYLAND	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - RETIRED				10b. KIND OF BUSINESS OR INDUSTRY OWN FAAM		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THADEUS GLOTFELTY				14. MOTHER'S MAIDEN NAME MARGARET FRATZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK.		16. SOCIAL SECURITY NO.		17. INFORMANT BLAINE GLOTFELTY		Address MC HENRY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Artemia DUE TO Hypertensive myocardial heart disease DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years 7 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/27/1956 , to 3/4/1956 , that I last saw the deceased alive on 3/4/1956 , and that death occurred at 4:57 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, State) Oakland Md DATE SIGNED 4 March 1956			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/7/56		22c. NAME OF CEMETERY OR CREMATORY THAYERVILLE		22d. LOCATION (City, town, or county) (State) THAYERVILLE, GARRETT Co, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Donald F. Newman				ADDRESS GRANTSVILLE, MD		24a. REC'D BY REGISTRAR Julia Rowan	
24b. REGISTRAR'S SIGNATURE				DATE 3/7/56			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "Jan 1, 1910"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Cincinnati, Ohio"]</p>		<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>	
<p>7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>8. MANNER OF DEATH [Faint text, possibly "Natural"]</p>	
<p>9. DATE OF DEATH [Faint text, possibly "Mar 10, 1956"]</p>		<p>10. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint signature]</p>	

BUREAU V. 5

MAR 19 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02893

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL (NEAR SANG RUN, MD.) 12 YEARS c. LENGTH OF STAY IN 1b 12 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANG RUN, MARYLAND d. STREET ADDRESS SANG RUN, MARYLAND e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First Middle Last </div> LLOYD NELSON GUARD				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month Day Year </div> MARCH 22ND, 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH NOV. 10TH., 1889		9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME FRANK GUARD			
14. MOTHER'S MAIDEN NAME MOLLEY TURNEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-18-2836			
17. INFORMANT MRS. STEPHEN DEWITT,		Address SANG RUN, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL 910.2 DUE TO CRUSHED CHEST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO CRUSHED CHEST (b) CRUSHED CHEST (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE IMMEDIATE </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ROCK SLIDE CRUSHED VICTIM WHILE WORKING UPON ROCK IN A STONE QUARRY.					
20c. TIME OF INJURY Month, Day, Year 8:15 a.m. 3-22-56 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) COUNTY STONE QUARRY SANG RUN GARRETT MD.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Notural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D. ACTING DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF March 24 1956		22c. NAME OF CEMETERY OR CREMATORY Oaklawn			
22d. LOCATION (City, town, or county) Sang Run Md		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE 3/24/56 Julie Rowan LR					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BATHING 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

MAR 29 1956

RECEIVED

2913

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. LENGTH OF STAY IN 1b 1-wk			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mathis				d. STREET ADDRESS 85x.3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Benjamin Middle Franklin Last Halterman				4. DATE OF DEATH March 5th, Day Year 1956 19			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1907	9. AGE (In years lost birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Mathias, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Liona P. Halterman				14. MOTHER'S MAIDEN NAME Anna E. See.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Thomas DeLauder, Sister.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 352x Atelectasis Rt. Lower Lobe DUE TO (b) 4 days DUE TO (c) 3 yrs Paraplegia							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 2 , 19 56 , to Mar 5 , 19 56 , that I last saw the deceased alive on Mar. 2 , 19 56 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur F. Jones M.D.				ADDRESS (Street, city or town, state) Oakland, Ind.			
PHYSICIAN'S NAME (Type) Arthur F. Jones, M.D.				DATE SIGNED 3-7-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-7-1956		22c. NAME OF CEMETERY OR CREMATORY Augusta Cemetery		22d. LOCATION (City, town, or county) (State) Augusta, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Doan Laurel Home Mortuary				24a. REC'D BY REGISTRAR 3/7/56		24b. REGISTRAR'S SIGNATURE Julia Rowan LR	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

2914
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY GARRETT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CO				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First MICHAEL Middle A. Last MADIGAN.				4. DATE OF DEATH Month MARCH Day 17 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 5-1866	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED B&O TRACKMAN.				10b. KIND OF BUSINESS OR INDUSTRY DEER PARK.		11. BIRTHPLACE (State or foreign country) U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME MICHAEL MADIGAN.				14. MOTHER'S MAIDEN NAME MARY GOLLIHAN.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT EDWARD MADIGAN DEER PARK MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Coronary Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 3 1/2 Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Smoking				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1952, to March 17 1956, that I last saw the deceased alive on March 11 1956, and that death occurred at 10:42 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph Calandrella M.D.				DATE SIGNED March 19-56			
PHYSICIAN'S NAME (Type) RALPH CALANDRELLA							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH-20-1956		22c. NAME OF CEMETERY OR CREMATORY DEER PARK CEMETERY		22d. LOCATION (City, town, or county) (State) DEER PARK MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden OAKLAND MD.				24a. REC'D BY REGISTRAR DATE 3/20/56		24b. REGISTRAR'S SIGNATURE Julia R. Rowan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED <i>John William Smith</i>		DATE OF DEATH <i>March 29, 1936</i>	
AGE <i>45</i>		SEX <i>Male</i>	
PLACE OF BIRTH <i>New York City</i>		CITY OF DEATH <i>New York City</i>	
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		SIGNATURE OF PHYSICIAN <i>Dr. J. H. Brown</i>	
SIGNATURE OF DECEASED <i>John W. Smith</i>		SIGNATURE OF WITNESS <i>John W. Smith</i>	
SIGNATURE OF NEXT OF KIN <i>John W. Smith</i>		SIGNATURE OF CLERK <i>John W. Smith</i>	
SIGNATURE OF REGISTRAR <i>John W. Smith</i>		SIGNATURE OF DEPUTY REGISTRAR <i>John W. Smith</i>	

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02895

2915 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u> COUNTY <u>Garrett</u>		CITY <u>Route 2, Frostburg</u>		TOWN <u>Route 2, Frostburg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Grantsville</u>		<u>40 yrs.</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Joseph E. McKenzie</u>				<u>March 3rd, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>Nov. 14th, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. COUNTRY OF WHAT COUNTRY?	
<u>Ret. Clay Miner</u>		<u>Fire Clay</u>		<u>Pennsylvania</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Francis McKenzie</u>				<u>Leahanna Warner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk</u>		<u>213-10-9896</u>		<u>RFD 2, Box 356</u> <u>Carl McKenzie, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.0 Acute myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>				<u>15 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>None</u>		<u>None</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 29, 1956</u> , to <u>March 3, 1956</u> , that I last saw the deceased alive on <u>March 2, 1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>A. Paige Strong</u> M.D.				DATE SIGNED <u>March 5, 1956</u>			
ADDRESS (Street, city, town, state)				ADDRESS (Street, city, town, state)			
<u>Salisbury, Penna.</u>				<u>Salisbury, Penna.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-6-1956</u>		<u>Greenville Cemetery</u>		<u>Greenville Township, Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3-6-56</u>		<u>Miss Nancy A. Rose</u>		<u>Joseph R. Durst</u>		<u>Frostburg, Md.</u>	

115287

CERTIFICATE OF DEATH

Reg. No. 115287

ALL DEATHS REPORTED TO THE DEPARTMENT OF HEALTH

NAME OF DECEASED: **John J. Sullivan**

AGE: **45**

RESIDENCE: **123 Main St., Boston, Mass.**

DATE OF DEATH: **Nov. 1, 1956**

CAUSE OF DEATH: **Myocardial Infarction**

PLACE OF DEATH: **Home**

DATE OF BIRTH: **Nov. 1, 1911**

SEX: **Male**

EDUCATION: **High School**

OCCUPATION: **Engineer**

RELIGION: **Catholic**

DATE OF BURIAL: **Nov. 3, 1956**

PLACE OF BURIAL: **St. Mary's Cemetery, Boston**

DATE OF INTERMENT: **Nov. 3, 1956**

NAME OF FUNERAL HOME: **John J. Sullivan**

TO: **John J. Sullivan**

DATE OF DEATH: **Nov. 1, 1956**

PLACE OF DEATH: **Home**

CAUSE OF DEATH: **Myocardial Infarction**

DATE OF BURIAL: **Nov. 3, 1956**

PLACE OF BURIAL: **St. Mary's Cemetery, Boston**

DATE OF INTERMENT: **Nov. 3, 1956**

NAME OF FUNERAL HOME: **John J. Sullivan**

TO: **John J. Sullivan**

DATE OF DEATH: **Nov. 1, 1956**

PLACE OF DEATH: **Home**

CAUSE OF DEATH: **Myocardial Infarction**

DATE OF BURIAL: **Nov. 3, 1956**

PLACE OF BURIAL: **St. Mary's Cemetery, Boston**

DATE OF INTERMENT: **Nov. 3, 1956**

NAME OF FUNERAL HOME: **John J. Sullivan**

TO: **John J. Sullivan**

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BUREAU V. 5

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2917

CERTIFICATE OF DEATH

02897
766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND X MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First JOHN Middle ROBERT Last MOON		4. DATE OF DEATH Month MARCH Day 8 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE-22-1892
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY DEER PARK	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME SOLOMON MOON		14. MOTHER'S MAIDEN NAME ANNA SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-03-829	
17. INFORMANT MRS HAZEL MOON		Address OAKLAND MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 24 , 19 56 , to March 8 , 19 56 , that I last saw the deceased alive on March 8 , 19 56 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. J. BARNETT		ADDRESS (Street, city or town, state) 25000 St Garretts Md	
PHYSICIAN'S NAME (Type) E. J. BARNETT		DATE SIGNED 2/10/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH-11-1956	
22c. NAME OF CEMETERY OR CREMATORY PLEASANT VALLEY CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR OAKLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden		ADDRESS OAKLAND MD	
24a. REC'D BY REGISTRAR 3/10/56		24b. REGISTRAR'S SIGNATURE Julia Brown	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

1956

RECEIVED

2918

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Adam CLARK		4. DATE OF DEATH Month MARCH Day 26 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED RAILROADER		10b. KIND OF BUSINESS OR INDUSTRY Track work	9. AGE (In years last birthday) 73 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JACKSON C. JACK RODEHEAVER		14. MOTHER'S MAIDEN NAME VIRGINIA FRIEND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-05-9389	
17. INFORMANT Lee Rodeheaver		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia - 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Renal Disease DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1955 , to March 26, 1956 , that I last saw the deceased alive on March 26, 1956 , and that death occurred at 12:50 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. E. Mance		ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 26 Mar 56	
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/28/1956	22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery	22d. LOCATION (City, town, or county) (State) Deer Park, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR 3/28/56		24b. REGISTRAR'S SIGNATURE Jubill. P. Pown JR	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2919

CERTIFICATE OF DEATH

02898

166

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>OAKLAND</u>		LENGTH OF STAY (in this place) <u>one day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL SWANTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>ROUTE #1</u>			
3. NAME OF DECEASED (Type or Print) <u>ALLEN C. RODEHEAVER</u>				4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>7</u> (Year) <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>OCTOBER 30, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>AMI RODEHEAVER</u>				14. MOTHER'S MAIDEN NAME <u>HULDA SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Mrs. Freda Boyce Swanton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Heart Disease</u>				<u>5 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>				<u>10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/7/56</u> , 19 <u>56</u> , to <u>3/7/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/7/</u> , 19 <u>56</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>[Signature]</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/10/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Deer Park, Md.</u>	
24. REC'D BY REGISTRAR <u>3/10/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Oakland, Md.</u>	

2010 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REG. NO. 10

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text] 3. AGE: [Faint text]

4. DATE OF BIRTH: [Faint text]

5. PLACE OF BIRTH: [Faint text]

6. OCCUPATION: [Faint text]

7. CAUSE OF DEATH: [Faint text]

8. MANNER OF DEATH: [Faint text]

9. PLACE OF DEATH: [Faint text]

10. DATE OF DEATH: [Faint text]

11. SIGNATURE OF PHYSICIAN: [Faint text]

12. SIGNATURE OF REGISTRAR: [Faint text]

13. SIGNATURE OF WITNESS: [Faint text]

14. SIGNATURE OF DECEASED: [Faint text]

15. SIGNATURE OF NEXT OF KIN: [Faint text]

16. SIGNATURE OF CLERK: [Faint text]

17. SIGNATURE OF JUDGE: [Faint text]

18. SIGNATURE OF SHERIFF: [Faint text]

19. SIGNATURE OF CORONER: [Faint text]

20. SIGNATURE OF JURY: [Faint text]

21. SIGNATURE OF COURT: [Faint text]

22. SIGNATURE OF JUDGE: [Faint text]

23. SIGNATURE OF SHERIFF: [Faint text]

24. SIGNATURE OF CORONER: [Faint text]

25. SIGNATURE OF JURY: [Faint text]

26. SIGNATURE OF COURT: [Faint text]

27. SIGNATURE OF JUDGE: [Faint text]

28. SIGNATURE OF SHERIFF: [Faint text]

29. SIGNATURE OF CORONER: [Faint text]

30. SIGNATURE OF JURY: [Faint text]

BUREAU V. S.

MAR 27 1956

RECEIVED

2010 CERTIFICATE OF DEATH

2010 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2920 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02899

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-NEAR GRANTSVILLE, MD.			c. LENGTH OF STAY IN 1b 8 YRS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-NEAR GRANTSVILLE, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS STAR RT., FROSTBURG., MD.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle SCHOMBERT Last				4. DATE OF DEATH Month MARCH Day 19th. Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 21st. 1878		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING RECENTLY - RETIRED COAL MINER			10b. KIND OF BUSINESS OR INDUSTRY GARRETT COUNTY, MD.		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME GEORGE SCHOMBERT				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-09-6524		17. INFORMANT WILLIAM PLATTER STAR RT., FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR. ACTING				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/21/56		22c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE		22d. LOCATION (City, town, or county) (State) GRANTSVILLE, GARRETT CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ronald J. Newman</i>				ADDRESS GRANTSVILLE, MD		24a. REC'D BY REGISTRAR DATE MAR 22 1956	
				24b. REGISTRAR'S SIGNATURE <i>d. H. Hedrick</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR FRIENDSVILLE</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>no</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRIENDSVILLE</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEROY WHITE UPHOLD</u>				4. DATE OF DEATH Month Day Year <u>MARCH 3 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>MARCH 13 1935</u>			
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Timber Industry</u>			
11. BIRTHPLACE (State or foreign country) <u>Friendsville</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Dayton Uphold</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. Cecil Savage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-323773</u>		17. INFORMANT Address <u>Cecil Savage</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON MONOXIDE POISONING</u> 8915 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> <u>Died as result of fall from auto & heart</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>March 3 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>County Road</u>			
20f. (City or town) <u>FRIENDSVILLE</u>		20g. (County) <u>GARRETT</u>		20h. (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. Bau</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. J. BAUMHARTNER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/3/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blooming Rose</u>			
22d. LOCATION (City, town, or county) <u>Friendsville, Md</u>		22e. (State) <u>Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack A. Friend</u>			
23a. ADDRESS <u>Friendsville</u>		23b. REC'D BY REGISTRAR <u>Feb. 5, 1956</u>		23c. REGISTRAR'S SIGNATURE <u>Mrs. Ruth Friend</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
DEATH CERTIFICATE OF DEATH
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 7 1956

RECEIVED

2922

CERTIFICATE OF DEATH

02901

Reg. Dist. No. 171

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Accident, Md.			c. LENGTH OF STAY IN 1b 20 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) MONROE D. YODER				4. DATE OF DEATH March 10 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1889		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired		10b. KIND OF BUSINESS OR INDUSTRY own farm		11. BIRTHPLACE (State or foreign country) Holmes Co., Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Yoder				14. MOTHER'S MAIDEN NAME Amanda Barkman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Ray Yoder, Accident, R.D. Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mel. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Mar, 1956 , to 10 Mar, 1956 , that I last saw the deceased alive on 9 Mar, 1956 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury Pa DATE SIGNED 10 Mar 56 ACTUAL SIGNATURE B.H. Hoke Jr M.D. B.H. Hoke Jr PHYSICIAN'S NAME (Type) B.H. Hoke Jr MD SALISBURY Pa.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Maple Grove		22d. LOCATION (City, town, or county) (State) Grantsville, Garrett Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Newman				ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR DATE Mar. 13, 1956 24b. REGISTRAR'S SIGNATURE J.B. Emory	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REVISED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02902/66

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Friendsville, Md. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) on County Road near Friendsville, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P. O. Address Terra Alta, R F D # 1, W.Va. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RALPHORD HENRY VAN SICKLE		4. DATE OF DEATH Month MARCH Day 3 Year 1936	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 15, 1915
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 5 Days 12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner Repairman		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
11. BIRTHPLACE (State or foreign country) Friendsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis VanSickle		14. MOTHER'S MAIDEN NAME Louetta Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 235-20-834	
17. INFORMANT Mrs. Louetta Kelly VanSickle, Terra Alta		Address W.Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARBON MONOXIDE POISONING 891.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 3/3 1936 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) County Road near Friendsville Garrett Co 20f. (City or town) Friendsville (County) Garrett (State) Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) E. I. BAUMGARTNER		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) RURAL		22b. DATE THEREOF March 6, 1936	
22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery		22d. LOCATION (City, town, or county) near Friendsville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Williamson		24a. REC'D BY REGISTRAR DATE 3/6/36	
ADDRESS Terra Alta, W.Va.		24b. REGISTRAR'S SIGNATURE Julius A. Roman	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED: [Illegible]</p>		<p>DATE OF DEATH: [Illegible]</p>	
<p>AGE: [Illegible]</p>		<p>SEX: [Illegible]</p>	
<p>RESIDENCE: [Illegible]</p>		<p>PLACE OF DEATH: [Illegible]</p>	
<p>CAUSE OF DEATH: [Illegible]</p>		<p>MANNER OF DEATH: [Illegible]</p>	
<p>DATE OF BURIAL: [Illegible]</p>		<p>PLACE OF BURIAL: [Illegible]</p>	
<p>SIGNATURE OF EXAMINER: [Illegible]</p>		<p>DATE: [Illegible]</p>	

BUREAU V. S.

MAR 7 1956

RECEIVED
3/12/56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02903 / 66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) SANG RUN, MD.		c. LENGTH OF STAY IN 1b LIFETIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, OAKLAND, MARYLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) STAR ROUTE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RANDALL Middle DWAINE Last WILBURN				4. DATE OF DEATH Month MARCH Day 22ND. Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 8TH., 1913	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME (FIRST AND MIDDLE UNK.) CONNEWAY				14. MOTHER'S MAIDEN NAME SADIE WI LBURN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 22-028-9373		17. INFORMANT Address MRS. JAMES WILBURN STAR RT., OAKLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 910.2 CRUSHED CHEST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BROKEN RT. SHOULDER DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ROCK SLIDE CRUSHED VICTIM WHILE WORKING UPON ROCK IN A STONE QUARRY.					
20c. TIME OF INJURY Month, Day, Year 8:15 a.m. 3-22 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) COUNTY STONE QUARRY SANG RUN GARRETT MD.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED MARCH 22ND., 1956	
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D. ACTING				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 23, 1956		22c. NAME OF CEMETERY OR CREMATORY Thayerville		22d. LOCATION (City, town, or county) (State) near Oakland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden Oakland Md				24a. REC'D BY REGISTRAR 3/25/56		24b. REGISTRAR'S SIGNATURE Julia Rowan	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after signing by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2925

CERTIFICATE OF DEATH

Reg. Dist. No.

02904/66

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b LIFETIME.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		d. STREET ADDRESS 00	
3. NAME OF DECEASED (Type or print) First MARY Middle MARTHA Last WOLF		4. DATE OF DEATH Month MARCH Day 15 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1871 OCT-16-1871
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OAKLAND MD.	
11. BIRTHPLACE (State or foreign country) OAKLAND MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME SAMUEL WOLF		14. MOTHER'S MAIDEN NAME MATILDA WOLF.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS JOSEPH KIENHOFER CUMBERLAND MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion? 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) disease INTERVAL BETWEEN ONSET AND DEATH 2 hours? years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Aug 48 , to 15 March 56 , that I last saw the deceased alive on 15 March 56 , and that death occurred at 2:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3/15/56 ACTUAL SIGNATURE Thomas D. Lushy M.D. PHYSICIAN'S NAME (Type) THOMAS F. LUSBY Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH-17-1956	
22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden		24a. RECEIVED BY REGISTRAR 3/17/56 DATE	
24b. REGISTRAR'S SIGNATURE Julia A. Rowan			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

116

BUREAU V. S.

RECEIVED

MAR 27 1956

3/17/56
CHANDLER MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2926 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04075/66**

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Crellin</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Imlayestown</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Teena</u> Middle <u>Gail</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>March</u> , Day <u>31</u> , Year <u>1956</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>May 1, 1946</u>		9. AGE (In years last birthday) <u>9</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Imlayestown, N. J.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>William Young</u>				14. MOTHER'S MAIDEN NAME <u>Florence Sisler</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>William Young, Imlayestown, N. J.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. Crushing injuries right chest wall with rupture of lung.</u> DUE TO (b) <u>2. Fracture Basal portion right skull</u> DUE TO (c) <u>3. Fracture shaft right femur, left radius & ulna, right mandible.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <u>Instant.</u> <u>n</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile skidded and ran into tree.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>9:00</u> p. m. <u>3/31/58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State route 39</u>			
20f. (City or town) <u>near Crellin Garrett Md.</u>				(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>E. I. Baumgartner M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>E. I. Baumgartner M. D.</u>				DATE SIGNED <u>3/31/56</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-4-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green wood.</u>		22d. LOCATION (City, town, or county) <u>Allentown, New Jersey</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Golden Oakland Md</u>				24a. REC'D BY REGISTRAR <u>4/1/56</u> 24b. REGISTRAR'S SIGNATURE <u>John H. Hays</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 24 1956

4-2-14

George Washington